Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN5278PCA	A. BUILDING _____ B. WING _____	03/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH SERVICES OF NEVADA PERSONAL C	1810 PINION RD ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments This findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. This Statement of Deficiencies was generated as a result of the State Relicensure survey completed on your agency on 3/25/10. The state relicensure survey was conducted at your agency by authority of Chapter 449, Personal Care Agencies. The patient census was 364. Twelve client records were reviewed. Three client contacts were made. Ten employee files were reviewed. The following regulatory deficiencies were found:	P 000		
P 140	Section 15(5) Infectious Disease 5. Provide for the prevention, control and investigation of infections and communicable diseases; This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the agency failed to provide an agency infection control policy that would provide for the prevention, control and investigation of infections and communicable diseases as required by statute. Review of documentation and interview with the infection control officer for the agency, revealed a lack of method for identifying, preventing,	P 140		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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P 140	Continued From page 1 controlling and investigating infections and communicable diseases for the clients of the agency. Client #3, 7, 8, 9, 10 were identified in serious occurrence reports to have been diagnosed with infectious disease. Client # 6 had an undiagnosed increased risk for infection from a draining wound. These incidences were reported to the Medicaid case manager. Review of documentation and interview revealed a lack of documented evidence of any follow up for investigation, prevention and control. Record review and interview revealed, for the clients not covered by a Medicaid case manager, there was a lack of any method to identify and report infectious disease to the infection control officer of the agency. Scope: 2 Severity: 2	P 140		